

be approved of by qualified oculists before purchase.

The final contribution by Dr. Colin Campbell on "Experience in base hospitals" was followed with interest. He stated that in the last war no standard forms had been provided to keep records, so they had to be obtained locally and paid for from the Canteen Fund. Surgical instruments for eye work were not ordered until 1918; then they came from a druggist, and consisted for the most part of museum pieces. Eserin had been ordered for a case of acute glaucoma, but it arrived some months later when the eye had been excised. Much trouble was occasioned by defective records of vision, and frequently the soldier's history was greatly delayed following his admission to hospital. Records while the patient is in hospital should be carefully kept. Many were lost in the last war that would now be useful to the Pension Board. Special equipment for testing malingerers should be available. Many men unfit for service owing to eye defects were taken overseas where it was impossible to use them, and they had to be returned at great expense, to be on the pension list for the rest of their lives. Such inefficiency should be guarded against. Dr. Campbell stated that much refraction and time-consuming treatment of functional cases had been required, and even operations for squint were numerous. Base hospitals should have both the giant and small magnets with a localizer.

At the Business Session the Committee on Visual Standards in Canada reported that their work had been completed, and that its report, when published, would serve as an expression of the considered opinion of the Canadian Ophthalmological Society in regard to what standards of vision in Canada should be.

A resolution of condolence was passed, standing, by the Society on the death of Dr. C. E. O'Connor, who was to have been one of the hosts of the Society at its meeting in Kingston.

It was decided to hold the third Annual Meeting of the Canadian Ophthalmological Society in Ottawa, on October 19, 1940, and the following officers were elected: *President*, Dr. W. H. Lowry; *Vice-president*, Dr. J. Vaillancourt; *Secretary-Treasurer*, Dr. Alexander E. MacDonald; *Council*: Drs. F. T. Tooke, W. G. Fraser, R. B. Boucher, R. E. Mathers and H. P. Folger.

Honorary Membership was conferred upon Dr. E. V. L. Brown, the Society's guest of honour.

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The earliest mention of ophthalmology occurs in a law book of Babylon-Assyria in 2250 B.C. Aristotle was the first comparative ophthalmologist. The first textbook on the eye which has come down to our day was written during the first half of the Eleventh Century in Bagdad. Leonardo da Vinci was the first to compare the action of the eye to a camera.—National Health Council.

## Letters, Notes and Queries

### Physiotherapy During the War and After

*To the Editor:*

The establishment of convalescent military hospitals in Canada would seem to be a logical "base line" war activity. Many convalescents require protracted orthopaedic treatment to achieve even partial recovery. Adequate treatment of such cases depends in the first place upon the services of thoroughly trained personnel and, secondly, upon proper equipment for up-to-date orthopaedics and physiotherapy.

To staff orthopaedic centres it is to be presumed that there will be no lack of competent orthopaedic surgeons and of nurses with the necessary qualifications or experience. It is also, however, absolutely necessary that there should be a sufficient number of expert physiotherapists, since the value of physiotherapy in the later treatment of orthopaedic cases cannot be overestimated. To meet military requirements, over and above present civilian needs, the number of available physiotherapists in Canada is insufficient, and additional training facilities, such as are now found only at the University of Toronto, should be provided at once for training additional physiotherapists. It is suggested that women with previous training in physical education are the most suitable candidates, and that undue delay might result in such women becoming absorbed in other less vitally important work.

Up-to-date orthopaedic centres should, of course, be provided with sufficient operating rooms, adequate equipment for x-ray work, diathermy and other lamp treatments. Buildings should be so laid out that sun porches will receive the maximum of direct sunlight in all seasons as well as shelter from winds. Each centre should include a medical gymnasium with apparatus for specialized treatments, so that each patient can receive the exercise best suited to his individual needs. A portion of this equipment might be built in the workshops which form part of each orthopaedic centre for making those splints, braces, casts and other aids which must be fitted to the individual patient.

An essential part of any such orthopaedic centre is equipment for hydrotherapy, facilities for which in Canadian hospitals are quite insufficient at the present time. The immense value of hydrotherapy in orthopaedic cases has been proved beyond question. Hydrotherapy is notably successful in the treatment of both joint and nerve injuries (the latter, of course, including injuries to the brain and cord.) Immersion in warm or hot water induces relaxation, and in some cases reduces irritability. The

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buoyancy of the water supports both limbs and trunk as no purely mechanical appliance can. Thus hydrotherapy decreases the discomfort of necessary remedial exercise and by simultaneously reducing both the irritability and the effort involved enables weakened muscles and feeble nervous impulses to produce voluntary movements through much wider arcs than would be possible out of the water, even with good mechanical aids. Hydrotherapy thus shortens very considerably the time necessary for recovery of function, which, of course, means a marked reduction in the duration of hospitalization.

Suitable equipment for hydrotherapy includes continuous baths and a pool or pools of sufficient size and depth to allow every sort of exercise. Pools should be equipped with such simple apparatus as is necessary to assist underwater exercise and should be capable of a fairly wide range of temperature adjustment. An essential feature is adequate equipment for the movement of patients into and out of the pool with as little fatigue and discomfort as possible. This is most important, as unnecessary pain and nervous tension greatly reduce the value of the treatment.

While open wounds without bone involvement often benefit from hot baths, the ordinary continuous bath is to be preferred in such cases for sanitary reasons. In field general hospitals improvised continuous baths of stout planking lined with stainless steel can be constructed by engineer services, thus permitting early commencement of passive and voluntary movements, stimulating healing, securing early restoration of function, and avoiding contractions. Such equipment would also be of value for neurotic cases. In this connection may be noted the need of orderlies trained to move patients correctly and to co-operate with physiotherapists in charge of the treatments.

Further features of orthopædic centres which should on no account be overlooked are facilities both for occupational therapy and for vocational training. For those patients who recover completely the last is not a serious problem, but many, while reaching their greatest possible return of function, will nevertheless be left with some degree of disability. It is vitally important, for social and economic as well as humanitarian reasons, that such handicapped men be trained as fully as possible to readjust themselves to take useful places in society.

The value of orthopædic centres of this sort was convincingly demonstrated during the last war. What is now needed is the application of the experience gained there, plus all the benefits of the intervening twenty years of progress in treatment and technique.

Apart from the obvious humanitarian considerations, there are many practical advantages to such a plan. In the first place, many patients who would otherwise be left with a partial disability for life would secure a sub-

stantially complete restoration of function. Secondly, those who cannot make a complete recovery would nevertheless be discharged with a minimum of disability. In both cases the country would be saved large and avoidable expenditures for pensions. By combining with reasonable restoration of function the training necessary for its effective use patients would leave such hospitals prepared to re-enter the life of the community with courage and confidence. Such satisfactory adjustments are of immense value in preventing discontent and unrest during the inevitable reconstruction following the dislocation of war. Lastly, it is worth considering that the value of such orthopædic centres would extend far beyond their military service; for they would certainly find full use for civilian cases after the war need has passed, as there is in Canada a serious lack of such facilities. It is to be hoped that in the detailed plans for medical services referred to by the Minister of National Defence due consideration has been given to the provision of orthopædic centres.

Yours truly,

BEATRICE LYMAN JOHNSTON, M.A.

Montreal,

December 26, 1939.

[The above letter calls attention to certain considerations which are of particular importance at the present time. Mrs. Johnston writes with the conviction and zeal that only comes from sad personal experience, and for that reason, if for no other, her views are worthy of attention.—Ed.]

## Abstracts from Current Literature

### Surgery

**Intussusception Due to Hæmangioma of the Jejunum.** Marchant, F. T.: *Arch. Surg.*, 1939, 39: 1040.

Benign tumours of the small intestine are of infrequent occurrence. Serious or even fatal complications may be associated with them. Among such tumours those of vascular origin are among the rarest. Brown has classified these into the following groups. (1) Multiple tumours of vascular arcades, forming nodules in the submucosa and associated with the arteries or veins. They form vascular nævi or cavernous hæmangiomas. (2) Submucosal tumours which grow toward the lumen of the intestine and may become ulcerated by pressure or trauma. (3) Submucosal tumours which may become polypoid in structure and grow to a size sufficient to obstruct the lumen or to bring about an intussusception. (4) Diffuse ring-like tumours which begin in the submucosa and involve the muscularis so that the lumen is constricted and an acute or chronic obstruction results.